MAIL OR FAX FORM TO:

TRISTAR
CLAIMS ADMINISTRATION
P.O. BOX 881267
SAN DIEGO, CA 92168-1267
FAX: (619) 683-9963

Liability Incident Report

Hoopa Valley Tribal Council

Claimant Details

NAME: _____ DOB: _____ HT: _____ WT: _____

HOME ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ SS#: _____

CLAIMANT'S STATUS: VISITOR: _____ EMPLOYEE: _____

WAS CLAIMANT WEARING GLASSES? _____ CONTACT LENSES?: _____

TYPE AND CONDITION OF SHOES? _____ HEEL SIZE: _____

Incident Details

DATE OF INCIDENT: _____ LOCATION: _____ TIME: _____

CONDITION OF INCIDENT LOCATION: (i.e., lighting, weather, etc.)

_____

_____

_____

DESCRIPTION OF INCIDENT:

_____

_____

_____

DESCRIPTION OF INJURY/LOSS:

_____

_____

_____

EMERGENCY MEDICAL CARE: _____ TRANSPORTED TO: _____

TRANSPORTED BY: _____ TREATMENT REFUSED: _____

Witness Details

1. WITNESS NAME: _____ DOB: _____

HOME ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO CLAIMANT: _____

2. WITNESS NAME: _____ DOB: _____

HOME ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO CLAIMANT: _____

Report Details

CLAIMANT'S VERSION OF INCIDENT:

_____

_____

_____

WITNESSES' VERSION OF INCIDENT:

_____

_____

_____

COMMENTS/SPECIAL HANDLING INFORMATION:

_____

_____

_____

TIME & DATE OF FIRST REPORT: _____ FIRST REPORT GIVEN TO: _____

ATTITUDE OF CLAIMANT: _____ ACTION TAKEN: _____

REPORT PREPARED BY: _____

POSITION: _____ DATE: _____